

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (332)

CERTIFICATE OF DEATH

10479

★ Reg. Dist. No. 351

1. PLACE OF DEATH:

County Newcastle
City or town Quaker
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Newcastle
City or town Quaker
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war 70

3. (a) FULL NAME

John T. Bealsworth

3. (b) Social Security Number

212-18-6231

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Clara J. Bealsworth

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Nov. 4 - 1866

8. AGE: Years 78 Months 11 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Martins, Md.
(Town, county, and state)

10. Usual occupation Miller

11. Industry or business Flour mill

12. Name John T. Bealsworth

13. Birthplace Maryland

14. Maiden name Bealsworth

15. Birthplace Maryland

16. Informant Mrs. Martha Taylor

Address Quaker, Md.

17. Date thereof Oct 20/45
(month) (day) (year)

Cemetery or crematory Trinity Churchyard

Location Newark, Md.

18. Funeral director Beane & Dinning

Address Snow Hill, Md.

19. 10/20/45 Registrar LeRoy Smith

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 19 45 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 20 19 45 to Oct 18 19 45

and that I last saw him alive on Oct 18 19 45

Immediate cause of death Respiratory Paralysis

Due to Cerebral Vascular Accident 10 wks

Due to Arteriosclerosis + senility

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert C. LaMar, M.D.

Address Snow Hill, Md. Date signed 10.20.45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester
 City or town Ocean City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Worcester
 City or town Ocean City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Aralanta Birch

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Jessie Birch

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1866 8. (c) If alive, give age _____ years

8. AGE: Years 79 Months 7 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace North Beach, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Samuel Merritt

13. Birthplace Maryland

14. Maiden name Isabelle (2)

15. Birthplace Maryland

16. Informant Mr. Harry Birch

Address Ocean City md

17. Burial Date thereof 10/14/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin md

18. Funeral director Anna B. Bourbon

Address Berlin md

19. 10-14 45 Helen F. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 - 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____

and that I last saw _____ alive on Oct 11 - 1945

Immediate cause of death _____ DURATION _____

Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Chas R. Law M. D. or other _____

Address Berlin md Date signed 10-13-45

MASSACHUSETTS DEPARTMENT OF HEALTH

Office of the Registrar

CERTIFICATE OF DEATH

1. Name of deceased (Print or write)

2. Date of death

3. Place of death

RECEIVED

OCT 18 1945

BUREAU V.S.

4. Signature of Registrar

5. Date of registration

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

CERTIFICATE OF DEATH

Reg. Dist. No. 10481 355

1. PLACE OF DEATH: Worcester
 County Berlin
 City or town Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Samuel E. Beale

3. (b) Social Security Number

4. Sex male 5. Color or race Cauc 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Sept 8 1925 8. (c) If alive, give age _____ years

8. AGE: Years 19 Months 1 Days 12 It less than one day _____ hrs. _____ min.

9. Birthplace Berlin Md
 (Town, county, and state)

10. Usual occupation Teacher11. Industry or business Carl Beale12. Name Carl Beale13. Birthplace Maryland14. Maiden name Alexis Richards15. Birthplace Maryland16. Informant Carl BealeAddress Berlin Md17. Burial Date thereof Oct 22 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. WesleyLocation Snow Hill Md R.F.D.18. Funeral director Anna A. BunboyeAddress Berlin Md19. 10-22 45 Helen F. Hayward

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 19 45 at 11:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Pulmonary tuberculosis DURATION two days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John L. Ray Dep. Reg. Exam M. D. or other _____Address Snow Hill Md Date signed 10/24/45

CERTIFICATE OF DEATH

RECEIVED
OCT 26 1935
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH:

County... Worcester

City or town... Bishopville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Worcester

City or town... Bishopville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, came war

3. (a) FULL NAME

Geo. W. Brittingham

3. (b) Social Security Number

4. Sex

male

5. Color or race

caucasian

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife... Martha Brittingham

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years 90 Months Days If less than one day
.....hrs.min.9. Birthplace... Berlin, Md.
(Town, county, and state)

10. Usual occupation... Farming

11. Industry or business

12. Name... Litt Brittingham

13. Birthplace... Md.

14. Maiden name... unknown

15. Birthplace

16. Informant... Harvey Brittingham

Address... Bishopville, Md.

17. Burial Date thereof Oct. 27, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Evergreen

Location... Berlin, Md.

18. Funeral director... Margaret H. Watson

Address... Pocomoke City, Md.

19. Oct. 25, 1945 Mrs. E. J. Rogers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct. 27, 1945 at 12:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him... alive on 19...

Immediate cause of death... Myocardial degeneration of heart

Due to... unknown

Due to...

Due to...

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

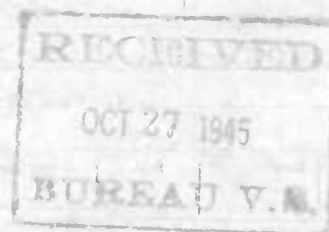
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... John L. Riney M.D. Exam.

Address... Bishopville, Md. Date signed 10/24/45

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

10483



Reg. Dist. No. 353

1. PLACE OF DEATH:

County..... Worcester
 City or town..... Bishopville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 30 yrs.
 Hospital, institution, or street address where death occurred:.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Worcester
 City or town..... Bishopville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Rural
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Full Name..... Nellie Ellen Bunting

3. (b) Social Security Number

4. Sex..... Female 5. Color of race..... White 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Willis L. Bunting
 6. (c) If alive, give age..... 55 years

7. Birth date of deceased (mo., day, yr.)..... June 16 1899

8. AGE: Years..... 46 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Delaware
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... Housewife

12. Name..... Edna Jimmons

13. Birthplace..... Md.

14. Maiden name..... Maude Kate Hickman

15. Birthplace..... Md.

16. Informant..... Willis L. Bunting

Address..... Bishop, Md. R.F.D.

17. Burial, cremation, or removal, Which..... Burial Date thereof..... Oct 31, 1945
 (month) (day) (year)

Cemetery or crematory..... O.O.F.

Location..... Bishopville, Md.

18. Funeral director..... M. Prater & Son

Address..... Libertyville, Del.

19. 10 30 45 Mrs. Roy Bury

(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct. 28 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944 to day of death and that I last saw her alive on 10-28-45

Immediate cause of death..... Carcinoma of breast with generalized metastasis.
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

DURATION

2 yrs.

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Frank R. Lewis M.D.

Address..... Hall's Md.

Date signed..... 10-29-45

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

NOV 1 1945

BUREAU OF VITALS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

10484 350
★ Reg. Diat. No.

1. PLACE OF DEATH:

County Worcester
 City or town Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? ..
 Hospital, institution, or street address where death occurred:
 ..
 How long in hospital or institution? ..

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Near Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ..

3. (a) FULL NAME

Ocie Ann Collins

3. (b) Social Security Number

4. Sex Female 5. Color or race negro 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Simone Sturgis
 6.(c) If alive, give age 78 years
 7. Birth date of deceased (mo., day, yr.) ? ? 1868
 8. AGE: Years 77 Months Days If less than one day
 .. hrs. .. min.

9. Birthplace Pocomoke-Worcester Maryland
 (Town, county, and state)

10. Usual occupation house wife

11. Industry or business

12. Name Frank Wise
 13. Birthplace Pocomoke County Va
 14. Maiden name Ellen Rouders
 15. Birthplace Stockton Md

16. Informant Ocie White
 Address Bank St., Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Oct 7 1945
 (month) (day) (year)
 Cemetery or crematory Halls Hill Cemetery
 Location Pocomoke City Md.

18. Funeral director Harvey Budshaw
 Address Pocomoke City Md.

19. Oct. 7 1945 Anne E. White
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .. 19 .. to .. 19 ..
 and that I last saw h. alive on .. 19 ..

Immediate cause of death Cancer of breast DURATION unknown

Due to ..

Due to ..

Other conditions ..

(Include pregnancy within 3 months of death)

Major findings of operations ..

..... Date of op.

Autopsy results ..

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .. Date of ..

Where did injury occur? .. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ..

Means of injury .. Injured at work?

23. SIGNATURE John L. Riley M.D. Exam
 M. D. or other

Address Brown Hill Md Date signed 10/5/45

MINNESOTA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
OCT 9 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore (50)

CERTIFICATE OF DEATH

10485

Reg. Dist. No. 350

1. PLACE OF DEATH

County Worcester
 City or town Pocomoke City Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yearsHospital, institution, or street address where death occurred: —How long in hospital or institution? —

3. (a) FULL NAME

Elizabeth J. Hancock

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Charles B. Hancock6. (c) If alive, give age 67 years
 7. Birth date of deceased (mo., day, yr.) Sept 7, 1878

8. AGE:	Years	Months	Days	It less than one day
	<u>67</u>	<u>0</u>	<u>25</u> hrs. min.

9. Birthplace Elizabeth Allegheny Penna.
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business —12. Name Andrew Brown13. Birthplace Scotland14. Maiden name Elizabeth Witherspoon15. Birthplace Scotland16. Informant Charles B. HancockAddress Pocomoke City Md.17. Burial Date thereof Oct 5-1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baptist & Hall HillLocation Pocomoke City Md.18. Funeral director Margarette StedmanAddress Pocomoke City Md.19. Oct 4 19 45 Anne E. White
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke City Md.
 (If outside city or town limits, write RURAL and give nearest town)Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 19 45 at 5:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19 43 to Oct 2 19 45and that I last saw him alive on Oct 2 19 45Immediate cause of death Myocardial Infarction DURATION 2 yearsDue to Arteriosclerosis

Due to

Other conditions Coronary Artery Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. G. White M. D. or otherAddress Wm. Charles B. Date signed 10-4-45

RECEIVED
OCT 6 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

10486

★ Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 73 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 417 Walnut Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Laura Etta McAllister

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Wm F. McAllister

7. Birth date of deceased (mo., day, yr.) March 15, 1872 6.(c) If alive, give age years

8. AGE: Years 73 Months 6 Days 16 If less than one day hrs. min.

9. Birthplace Sylvia Occombe - Virginia
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Wm H. Marshall

13. Birthplace Accomac County, Va

14. Maiden name Margaret Ross

15. Birthplace Accomac County, Va

16. Informant Mrs. E.W. Kelly

Address 512 Walnut St. Pocomoke Md.

17. (Burial, cremation, or removal, which?) Burial Date thereof Oct 4 1945
 (month) (day) (year)

Cemetery or crematory Bethany Methodist Church

Location Pocomoke City, Md

18. Funeral director H. Harverson (Stadshay)

Address Pocomoke City, Md.

19. Oct 4 1945 Anne E. White
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1945, at 11:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 1 1945
 and that I last saw him alive on Oct 1 1945

Immediate cause of death Sudden cardiac DURATION 1/2 hr
Personal hemorrhage 1 hr

Due to
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Ante-mortem results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. M. ... M. D. or other
Pocomoke City Address Date signed 10-3-45

RECEIVED

OCT 6 1945

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10487

★ Reg. Dist. No. 355

1. PLACE OF DEATH:

County... Worcester
 City or town... Ocean City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 33 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... md. County... Worcester
 City or town... Ocean City md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Harry Gibson Parsons.

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife... Annie Parsons.
 6.(c) If alive, give age... 64 years
 7. Birth date of deceased (mo., day, yr.) July 31, 1879.
 8. AGE: Years 67 Months 2 Days 13 If less than one day
hrs.min.

9. Birthplace... Maryland.
 (Town, county, and state)

10. Usual occupation... Post Road employee

11. Industry or business... Retired

12. Name... George E. Parsons.

13. Birthplace... md.

14. Maiden name... Caroline Larlow.

15. Birthplace... Maryland.

16. Informant... Mrs. Harry Parsons.

Address... Ocean City md.

17. Burial Date thereof... 10/16/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Jerusalem M.E. Church

Location... Parsonsburg md

18. Funeral director... Annie A. Benbowe

Address... Berlin md.

19. 10-16 45 Helen F. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct 14 1945 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him alive on Oct 12 1945

Immediate cause of death..... DURATION

Cerebral Hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE... Chas. R. Low M. D. or other

Address... Berlin md. Date signed Oct 15 45

CERTIFICATE OF DEATH

LOCAL HEALTH OFFICER'S SIGNATURE

DATE OF DEATH

REGISTERED MEDICAL EXAMINER

RECEIVED
OCT 26 1945
BUREAU

THIS DEPARTMENT HAS RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10488



Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town near Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town near Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Walter Lee Purcell

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male col single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Oct 27 1931

8. AGE:

Years

Months

Days

If less than one day

13 11 23 hrs. min.

9. Birthplace

near Pocomoke City
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Walter Purcell

13. Birthplace

Pocomoke City

MOTHER

14. Maiden name

Emma Suck

15. Birthplace

Pocomoke City

16. Informant

Emma Purcell

Address

Pocomoke City Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 21, 1945
(month) (day) (year)

Cemetery or crematory

Johnson's Neck Cemetery

Location

Pocomoke City, Md #R3

18. Funeral director

H. Harry Budden

Address

Pocomoke City, Md.

19.

Oct. 20, 1945
(Date rec'd by registrar)Anne E. White
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 191945midnight

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19____, to

19____

and that I last saw him..... alive on

19____

Immediate cause of death

Epilepsy

DURATION

3 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John L. Riley Jr. M.D.
M. D. or other
Brownlee M.D.
Address..... Date signed 10/20/45

RECEIVED

RECEIVED

RECEIVED

RECEIVED
OCT 23 1945
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

158

CERTIFICATE OF DEATH

10494

Reg. Dist. No. 35-4

1. PLACE OF DEATH: *Worcester*
 County *Worcester*
 City or town *Worcester*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Maryland* County *Worcester*
 City or town *Worcester*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME *Clair Roberts*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *col* 6. (a) Single, married, widowed, or divorced *single*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *July 22, 1945* 6. (c) If alive, give age years

8. AGE: Years Months Days If less than 000 day
2 *10* hrs. min.

9. Birthplace *Worcester, Md*
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name *Morris Roberts*

13. Birthplace *Worcester*

MOTHER 14. Maiden name *Margaret Marshall*

15. Birthplace *Worcester Md*

18. Informant *Margaret Marshall*

Address *Worcester Md*

17. *Burial* Date thereof *Oct 13 1945*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Mt Hope Cemetery*

Location *New Stockton, Md*

18. Funeral director *James Bennett*

Address *Stockton, Md*

19. *Oct 13* 19 *45* *Mary M. Ryan*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 13* 19 *45* at *12:30 a* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19 and that I last saw him alive on 19

Immediate cause of death *Compensated atherosclerosis*

DURATION *10 weeks*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *John L. Riley M.D.* M. D. or other

Address *Worcester, Md* Date signed *10/13/45*

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED
OCT 19 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH: County..... Worcester City or town..... Bishopville (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... 45 yrs. Hospital, institution, or street address where death occurred:..... How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... Maryland County..... Worcester City or town..... Bishopville (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2. (If veteran, name war..... World War I			
3. (a) FULL NAME James P. Rodney				3. (b) Social Security Number			
4. Sex male				5. Color of race white			
6. (a) Single, married, widowed, or divorced married				6. (b) Name of husband or wife Edward Doren Rodney			
7. Birth date of deceased (mo., day, yr.) Feb. 27, 1869				6. (c) If alive, give age 72 years			
8. AGE: Years 76				Months Days If less than one day			
9. Birthplace Md.				(Town, county, and state)			
10. Usual occupation Carpenter				11. Industry or business			
12. Name John B. Rodney				13. Birthplace Md.			
14. Maiden name Atlanta Birch				15. Birthplace Md.			
16. Informant John Rodney				Address Bishop, Md. P.F.D.			
17. Burial				Date thereof Oct. 17, 1945			
(Burial, cremation, or removal. Which?)				(month) (day) (year)			
Cemetery or crematory I.O.O.F.				Location Bishopville, Md.			
18. Funeral director M. Vasha Watson				Address Seelyville, Ark.			
19. (Date rec'd by registrar) Oct. 16, 1945				Register			

MEDICAL CERTIFICATION	
20. DATE OF DEATH Oct. 14, 1945, at 11:00 P.M.	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 13, 1945, to Oct. 14, 1945,
and that I last saw him alive on Oct. 14, 1945	22. VIOLENCE: If death was due to external causes, fill in the following:
Immediate cause of death Cerebral Hemorrhage	Accident, suicide, or homicide
DURATION 2 days	Where did injury occur?
Due to	(City or town) (County) (State)
Due to	Injured at home, farm, industry, public place (where?)
Other conditions	Means of injury
(Include pregnancy within 3 months of death)	Injured at work?
Major findings of operations	Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.	23. SIGNATURE G.E. James MD
Address Pelbyville, Ark.	Date signed 10-15-45

MAINE STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2. TIME ELAPSED SINCE DEATH

DATE OF DEATH

1. PORTADWILL, MAINE

RECEIVED

OCT 27 1945

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10491

Reg. Dist. No. 357

1. PLACE OF DEATH:

County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 yrs
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

No

3. (a) FULL NAME

Mary Hester Tingle

3. (b) Social Security Number

None

4. Sex _____ 5. Color or race _____ 6. (a) Single, married, widowed, or divorced _____

Female Colored Married

6. (b) Name of husband or wife Daniel E Tingle

6. (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) October 2 1875

8. AGE: Years 72 Months 0 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Snow Hill Worcester Maryland
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business _____

12. Name Henry Houston

13. Birthplace Maryland

14. Maiden name Unknown

15. Birthplace _____

16. Informant Grace Johnson

Address 215 N Locust St. Wilmington Del.

17. Burial Burial Date thereof 10-6-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ebenezer Cemetery

Location Snow Hill road

18. Funeral director Leanne K Dennis

Address Snow Hill road

19. 10-5-45 Re Roy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH October 3 1945 at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 3 1945 to Oct 3 1945
and that I last saw him alive on Sept 29 1945

Immediate cause of death

cerebral vascular
accident

Due to senility
+ arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert L. La Mar, MD

Address Snow Hill Date signed 10-5-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDED
OCT 8 1965
BUREAU OF A. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:

County Worcester
City or town Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mamie B. Truitt

Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Walter C. Truitt

7. Birth date of deceased (mo., day, yr.)

Oct. 5 - 1892

8. (c) If alive, give age 54 years

8. AGE:

Years

Months

Days

If less than one day

53

0

10

hrs.

min.

9. Birthplace

Snow Hill Worcester Md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

Oliver W. Truitt

13. Birthplace

Maryland

MOTHER

14. Maiden name

Rebecca Truitt

15. Birthplace

Thomas, Md

16. Informant

Walter C. Truitt

Address

Snow Hill, Md Rural #1

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Oct 17/45

(Month) (day) (year)

Cemetery or crematory

State Methodist

Location

Snow Hill, Md

18. Funeral director

Headsie & Dammey

Address

Snow Hill, Md

19. (Date rec'd by registrar)

10/17/45

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Worcester

City or town

Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

70

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 15

19. 45

at

1:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/1/45

19. 45

to

10/15/45

19. 45

and that I last saw him alive on

10/15/45

19. 45

Immediate cause of death Hypertension

Heart disease with congestive failure

DURATION

3 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul

Chen M.D.

M. D. or other

Address

Snow Hill

Date signed 10/16/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE SECRETARY OF WAR

RECEIVED
OCT 22 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County WorcesterCity or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Pocomoke City RFD 2
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name War _____

3. (a) FULL NAME

Elaine Miller Watson

3. (b) Social Security Number

4. Sex Female5. Color or race col6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Rev Leon A Watson7. Birth date of deceased (mo., day, yr.) December 17, 1904

6. (c) If alive, give age _____ years

8. AGE: Years 40 Months 10 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Salisbury, Roanoke Co N.C.
(Town, county, and state)10. Usual occupation Teacher

11. Industry or business

12. Name William R. Miller13. Birthplace Salisbury, Roanoke Co N.C.14. Maiden name Zulia Bowman15. Birthplace Salisbury, Roanoke Co N.C.16. Informant Rev Leon A WatsonAddress Pocomoke City RFD 2 Md17. burial Date thereof Oct 22, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory SalisburyLocation Salisbury N.C.18. Funeral director Elias H WardAddress Marion Md.19. Oct. 18 19 45 Annie E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 19 45 at 10:5 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 45 to Dec 17 19 45and that I last saw him alive on Dec 15 19 45Immediate cause of death Reflux

DURATION

Due to Cause of Reflux

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. Miller M. D. or other _____Address Pocomoke City Date signed 10/17/45

REC-10
OCT 22 1945
BUREAU V.A.